OB/GYN Medical Billing in 2026: Why Denials Are Rising and How Practices Can Protect Revenue

OB/GYN practices provide some of the most clinically complex and important care in healthcare. They also operate within one of the most challenging billing environments in the industry. Routine office visits, surgical procedures, global maternity packages, preventive screenings, in office diagnostics, and high-risk pregnancy management often occur within the same practice and sometimes on the same day. Each service is billed under payer policies that can vary significantly in terms of coverage, coding requirements, and documentation standards.

As a result, OB/GYN medical billing creates more opportunities for denials than almost any other specialty. In 2026, those challenges are becoming even greater. The reason is not changing clinical care. The real drivers are stricter payer policies, more demanding documentation requirements, and increasingly complex coding expectations.

If your OB/GYN practice is experiencing higher denial rates, growing accounts receivable days, or revenue that does not align with patient volume, the underlying issue is often found within the billing process. This guide explains what is driving these challenges, why they are happening, and what successful OB/GYN practices are doing to protect revenue.

GoSourceMD is a HIPAA and SOC 2 Type 2 certified medical billing partner serving OB/GYN practices across the United States. Visit gosourcemd.com to learn how we help women's health practices strengthen and protect their revenue cycle.

Discover the five most common OB/GYN billing mistakes and practical ways to avoid them-- Read More Here

Why OB/GYN Billing Is Different From Other Specialties

Before exploring the common causes of revenue loss, it is important to understand why OB/GYN billing is inherently more complex than many other specialties.

The complexity is not simply a matter of perception. It is built into the structure of the specialty itself.

First, OB/GYN practices manage multiple billing models at the same time. A single practice may bill global maternity packages for obstetric patients, fee for service evaluation and management codes for gynaecology visits, surgical global periods for procedures, and preventive care codes for annual wellness appointments. Each model follows different rules, documentation standards, and payer requirements.

Second, OB/GYN care often spans extended periods of time. A maternity patient may remain under a provider's care for ten months or longer. During that period, insurance coverage can change, prior authorization requirements may be updated, and patient financial responsibility may shift. Maintaining billing accuracy throughout a long episode of care requires a level of coordination that is rarely needed in specialties where treatment is shorter and more episodic.

Third, OB/GYN practices frequently provide services that require prior authorization. In 2026, many payers continue expanding those requirements. Genetic testing, advanced diagnostic ultrasounds, certain surgical procedures, and maternal fetal medicine referrals commonly require approval before services are rendered. Missing even one authorization can result in a denial that may take weeks to resolve and, in some cases, may never be recovered.

The Global OB Package: Where Significant Revenue Is Lost

The global obstetric package remains the foundation of maternity billing. A single code covers routine antepartum care, delivery services, and postpartum care through six weeks after delivery.

While the model is intended to simplify billing, it is also one of the most common sources of revenue loss for OB/GYN practices.

The challenge comes from understanding which services are included in the package and which services can be billed separately. When billing teams lack a clear and consistent process for managing these distinctions, two problems often occur at the same time.

Separately billable services may be absorbed into the global package and never billed. At the same time, services that should be included within the package may be billed separately, creating audit exposure and potential payer recoupments.

Ultrasounds Beyond Routine Limits

Most commercial insurance plans cover two to three ultrasounds during an uncomplicated pregnancy. Additional ultrasounds often require documented medical necessity and may also require prior authorization.

Practices that do not carefully monitor payer specific ultrasound limits risk either losing legitimate reimbursement opportunities or generating avoidable denials for additional scans.

High Risk Pregnancy Services

Complicated pregnancies involving conditions such as gestational diabetes, hypertension, placenta previa, or multiple gestation often require additional monitoring and management services.

Many of these services fall outside the global package and can be reimbursed separately when properly documented. Practices that treat all obstetric patients the same from a billing perspective may overlook substantial revenue opportunities associated with high-risk pregnancies.

Services Unrelated to Pregnancy

Patients receiving obstetric care may still require treatment for unrelated conditions during pregnancy.

Visits for issues such as urinary tract infections, dermatological concerns, or unrelated pelvic complaints are generally separate from obstetric care and may be billed independently when appropriate. The global package applies to maternity related services, not every service delivered during the pregnancy period.

The Visit Count Challenge

Care transfers during pregnancy create another common billing risk.

When a patient transfers from one provider to another, the receiving practice may incorrectly bill a full global package without accounting for antepartum services already provided elsewhere. This can create overpayment exposure and increase audit risk.

Maintaining an accurate count of antepartum visits and clearly documenting that information during care transitions is essential for billing compliance and reimbursement accuracy.

The 2026 Billing Transition Every OB/GYN Practice Must Prepare For

A significant change to obstetric CPT coding is approaching.

A new framework replacing the current global obstetric package structure is scheduled to take effect on January 1, 2027. However, preparation must begin much sooner, and practices that delay planning until late 2026 may face unnecessary disruptions.

For pregnancies with an initial ten-week visit occurring on or after September 1, 2026, practices will need to begin using standard evaluation and management codes for antepartum visits rather than relying on traditional global package coding. Modifier TH will need to be appended to maternity related evaluation and management services to distinguish them from non-maternity encounters.

Although this may appear straightforward, implementation can be challenging.

Every payer within your network should be tested for Modifier TH acceptance before September 1. Insurance carriers that have not properly configured their systems may reject claims containing the modifier.

Discovering these issues after claims have already begun accumulating can lead to significant delays, rework, and revenue disruption. Practices that prepare early by validating payer readiness and testing claim workflows will be in a much stronger position when the transition takes effect.

The organizations that navigate this change successfully will not be the ones reacting to year end updates. They will be the practices that begin preparing and testing their processes well in advance.

Why OB/GYN Modifier Errors Are the Leading Cause of Denials

Modifier errors continue to be one of the most common reasons for claim denials in OB/GYN billing. In 2026, payer audit systems are increasingly designed to identify claims with frequent modifier use and route them for additional review. This means a modifier mistake does more than affect a single claim. It can attract attention to broader billing patterns across the practice.

Modifier 25

Modifier 25 is one of the most frequently misused modifiers in OB/GYN billing. It should be used when a provider performs a procedure and also provides a separately identifiable evaluation and management service during the same visit.

The most common mistake occurs when Modifier 25 is appended to an E/M service that only documents the evaluation leading to the procedure itself. In those situations, the evaluation is considered part of the procedure and does not qualify as a separate service.

To support Modifier 25 appropriately, the documentation must show a distinct complaint, separate assessment, and independent treatment plan that stands on its own apart from the procedure performed.

Modifier 22

Modifier 22 is used when a procedure requires substantially greater effort than what is normally described by the code.

Examples may include a particularly complex caesarean section, a hysterectomy involving extensive adhesions, or an operative hysteroscopy complicated by unexpected findings.

Successful reimbursement depends on detailed documentation. The operative report must clearly explain the additional work performed and the factors that increased the complexity of the procedure. Without this level of detail, the claim is likely to be denied during review.

Modifier 59 and X Modifiers

Modifier 59 is intended for situations where two procedures that are normally bundled were performed as separate and distinct services.

In 2026, payers increasingly prefer the more specific X modifiers when applicable. Examples include XS for a separate anatomical structure, XE for a separate encounter, and XP for a separate practitioner.

Using the most specific modifier available helps reduce audit risk and provides clearer justification for reimbursement.

The Five OB/GYN Billing Mistakes Practices Make Most in 2026

Treating the Global Package as a Catch All

Many billing teams assume the global obstetric package covers every service provided during a maternity episode. In reality, numerous services fall outside the package and may be billed separately.

Without a clearly defined internal policy and an effective charge capture process, practices often fail to bill for services that qualify for separate reimbursement, resulting in avoidable revenue loss.

Missing Prior Authorization for Imaging and Genetic Testing

Services such as additional diagnostic ultrasounds, foetal echocardiograms, genetic carrier screening, and non-invasive prenatal testing frequently require prior authorization from commercial payers.

When authorization is not obtained before the service is performed, practices often receive medical necessity denials that can be extremely difficult to overturn. The most effective approach is securing authorization before treatment rather than attempting to resolve issues after the fact.

Failing to Separate Gynaecology Visits From Obstetric Care

Patients who are actively receiving obstetric care may still present with gynaecologic concerns unrelated to their pregnancy.

These visits may qualify as separately billable evaluation and management services. Bundling them into the global package can lead to missed revenue, while billing them without clear documentation may trigger payer audits.

The clinical record should clearly demonstrate that the gynecologic concern was separate from the obstetric episode of care.

Using Unspecified Diagnosis Codes When More Specific Codes Are Available

The 2026 ICD 10 updates place greater emphasis on diagnostic specificity across several OB/GYN conditions.

Pelvic pain is one example where laterality should be reported whenever it is documented in the medical record. Submitting unspecified diagnosis codes when more detailed information is available creates reimbursement risk and may also raise compliance concerns.

Payers increasingly compare CPT coding with diagnosis specificity and flag inconsistencies for review.

Not Billing Add On Code 99459 for Pelvic Exams

Code 99459 allows practices to report the clinical staff time and supplies associated with pelvic examinations performed in office settings.

It may be billed in addition to a standard evaluation and management service when applicable. Despite performing pelvic examinations regularly, many OB/GYN practices do not report this code consistently, resulting in missed reimbursement opportunities.

What a High Performing OB/GYN Billing Workflow Looks Like

Practices that consistently protect revenue tend to follow a structured billing process designed specifically for the complexity of OB/GYN care.

They verify insurance eligibility at every visit rather than only at the beginning of care. A patient who changes insurance during pregnancy can create significant billing issues if those changes are not identified promptly. Ongoing eligibility verification helps prevent these denials before they occur.

They maintain a current antepartum visit log for every obstetric patient. This log tracks visit counts, rendering providers, and partial billing situations. Accurate tracking becomes especially important when patients transfer care or receive services from maternal fetal medicine specialists.

They use a dedicated prior authorization tracking process. Authorization numbers, approval dates, service limitations, and expiration dates are monitored within a structured workflow rather than relying on manual reminders or disconnected notes.

They conduct regular coding audits. A sample of charts is reviewed against submitted claims to verify evaluation and management levels, modifier usage, and global package compliance. The goal is to identify trends and correct issues before payers identify them.

They work with billing professionals who specialize in OB/GYN. Specialty specific expertise often leads to higher clean claim rates, fewer denials, and stronger revenue recovery than a generalist billing approach.

Why OB/GYN Practices Are Choosing to Outsource Billing in 2026

OB/GYN billing continues to become more complex due to global package management, evolving coding requirements, expanding authorization rules, and increasingly detailed payer documentation standards.

At the same time, experienced OB/GYN billing professionals are difficult to recruit, costly to retain, and require ongoing training to remain current.

For many practices, outsourcing has become a practical solution.

At GoSourceMD, we provide OB/GYN medical billing services for practices throughout the United States using workflows specifically designed for women's health. Our team manages global package tracking, antepartum visit counts, prior authorization follow up, modifier review, preparation for the September 2026 transition, and monthly coding audits supported by ongoing quality review.

As a HIPAA and SOC 2 Type 2 certified organization, we maintain rigorous standards for protecting patient and financial information.

If your practice is experiencing rising denial rates, increasing accounts receivable days, or revenue that does not align with patient volume, a structured review of your billing workflow can help identify the underlying causes and create a clear path toward improvement.

The Bottom Line

OB/GYN medical billing in 2026 demands accuracy, consistency, and attention to detail.

The practices that successfully protect revenue are those that treat global maternity care, gynaecology visits, surgical procedures, preventive services, and diagnostic testing as distinct billing categories, each with its own documentation requirements, authorization rules, and payer expectations.

Practices that rely on habit rather than structured workflows often face higher denial rates, slower payments, and greater revenue leakage.

In OB/GYN, billing errors carry significant financial consequences, and opportunities to recover lost revenue often disappear quickly. The practices that build disciplined billing processes today will be in the strongest position to protect revenue and maintain financial stability as payer requirements continue to evolve.

Frequently Asked Questions

Q1. What makes OB/GYN medical billing more complex than other specialties?

OB/GYN practices manage several billing models at the same time, including global maternity packages, fee for service gynaecology visits, surgical global periods, and

preventive care services. These billing models often overlap within the same day and require different coding, documentation, and reimbursement rules.

In addition, OB/GYN providers manage long episodes of care during which insurance coverage, authorization requirements, and patient financial responsibility can change multiple times. Combined with frequent prior authorization requirements, payer specific reproductive health policies, and extensive modifier usage in surgical billing, these factors make OB/GYN one of the most complex specialties from a billing perspective.

Q2. What services are not included in the global obstetric package?

The global obstetric package generally includes routine antepartum care within the allowed visit count, delivery services, and standard postpartum care.

Several services fall outside the package and may be billed separately when supported by proper documentation. These commonly include ultrasounds that exceed payer specific routine limits, laboratory testing, diagnostic services, procedures unrelated to the pregnancy, hospital admissions for non-obstetric conditions, and additional services associated with high-risk pregnancy management.

Failing to identify and bill these separately reimbursable services remains one of the most common causes of revenue leakage in OB/GYN practices.

Q3. What is changing in OB/GYN billing for September 2026?

For pregnancies with an initial ten-week visit occurring on or after September 1, 2026, practices will begin reporting antepartum visits using standard evaluation and management codes rather than traditional global package coding.

Modifier TH must be added to maternity related evaluation and management services to identify them as part of an obstetric episode of care.

To avoid claim disruptions during the transition, practices should test Modifier TH acceptance with every commercial payer before September 1 and verify that payer systems are prepared to process these claims correctly.

Q4. When should Modifier 25 be used in OB/GYN billing?

Modifier 25 should be used when a provider performs a procedure and also provides a significant and separately identifiable evaluation and management service during the same visit.

For example, a provider may perform a procedure while also evaluating and managing an unrelated gynaecologic concern. In these situations, the documentation must clearly show a separate complaint, assessment, and treatment plan that is independent of the procedure itself.

Modifier 25 should not be reported when the evaluation and management service simply represents the assessment that led to the procedure being performed.

Q5. Why should OB/GYN practices consider outsourcing their billing?

OB/GYN billing requires a level of specialty specific expertise that many general billing teams do not possess. Managing global obstetric packages, preparing for coding transitions, tracking prior authorizations, applying surgical modifiers correctly, and navigating preventive care coding all require detailed knowledge of the specialty.

The financial impact of billing errors in OB/GYN can be substantial, including underpayments, denied claims, missed reimbursement opportunities, and increased audit risk.

Partnering with an experienced OB/GYN billing specialist gives practices access to dedicated expertise, structured quality control processes, and greater visibility into revenue cycle performance.